

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:

02-14

2. STATE:

Virginia

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL
SECURITY ACT (MEDICAID)

4. PROPOSED EFFECTIVE DATE

September 1, 2002

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 447

7. FEDERAL BUDGET IMPACT:

a. FFY 2003 ~~\$(8,995,825)~~ 4,467,912b. FFY 2004 ~~\$(9,227,815)~~ 4,613,907

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19 A, pp1, 1.1, 1.2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):Replaces page 1
Add pages 1.1 and 1.2

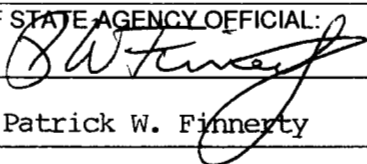
10. SUBJECT OF AMENDMENT:

Inpatient Hospital Reimbursement Reduction

GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL☒ OTHER, AS SPECIFIED: Secretary,
Health and Human Resources

12. SIGNATURE OF STATE AGENCY OFFICIAL:



13. TYPED NAME:

Patrick W. Finnerty

14. TITLE:

Director

15. DATE SUBMITTED:

8/25/2002

16. RETURN TO:

Dept. of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Attn: Reg. Coordinator

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

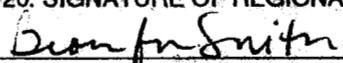
APR 15 2003

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

09/01/2002

20. SIGNATURE OF REGIONAL OFFICIAL:



21. TYPED NAME:

Charlene Brown

22. TITLE:

Deputy Director, CMSO

23. REMARKS: Pen Ink Fiscal Impact - state had
entered total comparable

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT SERVICES**CHAPTER 70.****METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES;
INPATIENT HOSPITAL CARE.****PART V.****INPATIENT HOSPITAL PAYMENT SYSTEM.****Article 1.****Application of Payment Methodologies.****12 VAC 30-70-200. Repealed.****12 VAC 30-70-201. Application of payment methodologies.**

- A. The state agency will pay for inpatient hospital services in general acute care hospitals, rehabilitation hospitals, and freestanding psychiatric facilities licensed as hospitals under a prospective payment methodology. This methodology uses both per case and per diem payment methods. Article 2 (12 VAC 30-70-221 et seq.) describes the prospective payment methodology, including both the per case and the per diem methods.
- B. Article 3 (12 VAC 30-70-400 et seq.) describes a per diem methodology that applied to a portion of payment to general acute care hospitals during state fiscal years 1997 and 1998, and that will continue to apply to patient stays with admission dates prior to July 1, 1996. Inpatient hospital services that are provided in long stay hospitals and state-owned rehabilitation hospitals shall be subject to the provisions of Supplement 3 (12 VAC 30-70-10 through 12 VAC 30-70-130).
- C. Transplant services shall not be subject to the provisions of this part. These services shall continue to be subject to 12 VAC 30-50-100 through 12 VAC 30-50-310 and 12 VAC 30-50-540.
- D. Reduction of Payments Methodology.
 - 1. For state fiscal years (FYE) 2003 and 2004, the DMAS shall reduce payments to hospitals participating in the Virginia Medicaid Program by \$8,935,825 total funds, and \$9,227,815 total funds respectively. For purposes of distribution, each hospital's share of the of the total reduction amount shall be determined as follows:

TN No. 02-14
Supersedes
TN No. 00-07

Approval Date APR 15 2003

Effective Date 9/1/2002

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT SERVICES

2. Determine base for revenue forecast:
 - a. The Department of Medical Assistance Services (DMAS) shall use, as a base for determining the payment reduction distribution for hospitals Type I and Type II, net Medicaid inpatient operating reimbursement and out patient reimbursed cost, as recorded by the DMAS for state fiscal year 1999 from each individual hospital settled cost reports. This figure is further reduced by 18.73%, which represents the estimated state wide HMO average percent of Medicaid business for those hospitals engaged in HMO contracts, to arrive at net baseline proportion of non-HMO hospital Medicaid business.
 - b. For freestanding psychiatric hospitals, the DMAS shall use estimated Medicaid revenues for the 6 month period (1-1-01 through 6-30-01), times two, and adjusted for inflation by 4.3% for state fiscal '02, 3.1% for state fiscal '03, and 3.7% for state fiscal '04 as reported by DRI-WEFA, Inc.'s hospital input price level percentage moving average.
3. Determine forecast revenue:
 - a. Each Type I hospital's individual state fiscal '03 & '04 forecast reimbursement is based on the proportion of non-HMO business (see 2. a. above) with respect to DMAS forecast of SFY '03 & '04 inpatient and out patient operating revenue for Type I hospitals. *Forecast is based on utilization and inflation*
 - b. Each Type II, including freestanding psychiatric, hospital's individual state fiscal '03 & '04 forecast reimbursement is based on the proportion of non-HMO business (see 2. a. and 2. b above) with respect to the DMAS forecast of SFY '03 & '04 inpatient and out patient operating revenue for Type II hospitals.
4. Each hospital's total yearly reduction amount is equal to their respective state fiscal '03 and '04 forecast reimbursement as described above in 3.a. and 3.b., times 3.235857 percent for state fiscal '03, and 3.235857 percent, subject to revision by DMAS annual budget forecast, for state fiscal '04, not to be reduced by more than \$500,000 per year.

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**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT
SERVICES**

5. Reductions shall occur quarterly in four amounts as offsets to remittances. Each hospital's payment reduction shall not exceed that calculated in 4. above. Payment reduction offsets not covered by claims remittance by May 15, 2003 and 2004, will be billed by invoice to each provider with the remaining balances payable by check to the Department of Medical Assistance Services before June 30.

12 VAC 30-70-205. REPEALED.

Article 2.

Prospective (DRG-Based) Payment Methodology.

12 VAC 30-70-210. Repealed.

12 VAC 30-70-211. Reserved.

12 VAC 30-70-221. General.

A. Effective July 1, 2000, the prospective (DRG-based) payment system described in this article shall apply to inpatient hospital services provided in enrolled general acute care hospitals, rehabilitation hospitals, and freestanding psychiatric facilities licensed as hospitals, unless otherwise noted.

B. The following methodologies shall apply under the prospective payment system:

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